

**INSTRUCTIONS**

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

01032

Reg. Dist. No. 291

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Talbot		MARYLAND		STATE Maryland		COUNTY Talbot	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN St. Michaels,		Life		TOWN St. Michaels,		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
Tyrone Westley Cannon				1 15 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
M	Colored		8/9/55	Yrs.	Months 5	Days 6	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				St. Michaels, Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Wilson Cannon				Doris Thomas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)				Wilson Cannon			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
491X IMMEDIATE CAUSE (A)				Branch Pneumonia		3 days	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
D							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at 2:15 P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
R. Lane Wright				St. Michaels		1-16-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		1/17/56		New Colored Cemetery		St. Michaels, Talbot, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE JAN 17 1956		Mrs. R. C. Sethis		Norman D. Marshall		St. Michaels, Md.	

CERTIFICATE OF DEATH

BUREAU V. 5

JAN 7 1956

RECEIVED

1955

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Talbot</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Queen Anne's</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>40 EASTON</u>	LENGTH OF STAY (in this place) <u>7 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Queen Anne 176-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH: 1 22 1956	
<u>Mrs. LEWIS ANNA COOPER</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>Jan 5-1872</u>
9. AGE last birthday: <u>84 yrs.</u>		10. BIRTHPLACE (State or foreign country): <u>Maryland</u>	11. CITIZEN OF WHAT COUNTRY? <u>USA</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
13. FATHER'S NAME: <u>Mr. Samuel Fox</u>		14. MOTHER'S MAIDEN NAME: <u>Henrietta Cox</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Mr. William H. Crofts, Sr. Queen Anne's</u>	
10. SOCIAL SECURITY NO.			
15. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
332X			
IMMEDIATE CAUSE (A) <u>Cerebral atherosclerosis</u>			
ANTECEDENT CAUSE (B) <u>Myocardial scarring</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Advanced arteriosclerosis</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/14</u> , 1956, to <u>1/22</u> , 1956, that I last saw the deceased alive on <u>1/22</u> , 1956, and that death occurred at <u>7:45 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>23 Jun 1956</u>	
M.D. <u>Carson</u>			
23. BURIAL CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>125/56</u>		<u>Landing Park</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/22/56</u>		REGISTRAR'S SIGNATURE <u>N.A. Newen</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>Carson</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 30 1956

RECEIVED

1956

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Talbot</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>40</u> <u>Easton</u>		LENGTH OF STAY (in this place) <u>8 da.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>40</u> <u>Easton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>80</u> <u>Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>5 South Street</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
(First) <u>Lily</u> (Middle) <u>Mae</u> (Last) <u>Dawkins</u>				1-6 1956			
5. SEX: <u>Fe</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH: <u>Feb 26, 1883</u>	9. AGE last birthday: <u>72</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY: <u>QW</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME: <u>Mr. Charles Leverton</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah Elizabeth Thompson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mr. Edward K. Dawkins</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Myocardial Infarct</u>							
ANTECEDENT CAUSE (B) <u>Coronary Thrombosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10:30</u> , 19 <u>56</u> , to <u>11:30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 9, 1956</u> , and that death occurred at <u>11:30</u> A.M., from the causes and on the date stated above.							
SIGNATURE: <u>[Signature]</u>		M. D. <u>[Signature]</u>		DATE SIGNED: <u>Jan 9, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF: <u>Jan 9, 56</u>		NAME OF CEMETERY OR CREMATORY: <u>Spring Neo</u>		LOCATION (City, town, or county) (State): <u>Easton</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>1-7-56</u>		REGISTRAR'S SIGNATURE: <u>[Signature]</u>		24. FUNERAL DIRECTOR: <u>[Signature]</u>		ADDRESS: <u>[Address]</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 12 1956

RECEIVED



CERTIFICATE OF DEATH

1956

*[Faint, mostly illegible handwritten text in the form fields]*

BUREAU V. S.

JAN 30 1956

RECEIVED

1957

## CERTIFICATE OF DEATH

Reg. Dist. No. 290...

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>TALBOT</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Laraine</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>140 EASTON</u>	LENGTH OF STAY (In this place) <u>36 hrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Preston</u>	<u>05X-2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hosp.</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Stella Foster</u>		OF DEATH: <u>1</u> <u>18</u> <u>1956</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>MARCH 15 1908</u>
9. AGE last birthday <u>47</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months	Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>H.W.</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>			
13. FATHER'S NAME: <u>Joseph Stevens</u>		14. MOTHER'S MAIDEN NAME: <u>Josephine Wing</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS: <u>Emmons Nelson Foster (husb)</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Heart failure</u>			
ANTECEDENT CAUSE (B) <u>Hypertension</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
22. I hereby certify that I attended the deceased from <u>1/16</u> , 19 <u>56</u> to <u>1/18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/18</u> , 19 <u>56</u> , and that death occurred at <u>5:20</u> PM, from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>1/19/56</u>	
M. D. <u>Easton</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal - Burial</u>		DATE THEREOF <u>1/24/1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Rock Cemetery</u>		LOCATION (City, town, or county) (State) <u>R.F.D. #1 Cambridge, Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/22/56</u>		REGISTRAR'S SIGNATURE <u>H.D. Neerius</u>	
FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>Cambridge, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 30 1956

BUREAU V. S.

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 153C 1-55 104

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Iter 5, Film 192 2-15-56 et

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>Easton</u>		LENGTH OF STAY (In this place) <u>8 mo</u>		CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>Easton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>Bella Henley Gallup</u>				<u>Jan. 28 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>CO</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>May 19, 1887</u>	9. AGE last birthday <u>68</u> yrs	IF UNDER 1 YEAR Months <u>8</u> Days <u>9</u>	IF UNDER 24 HRS Hours <u>1</u> Min.	
10a. U.S.A. OCCUPATION (Give kind of work during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House</u>		11. BIRTHPLACE (State or foreign country) <u>Princess Anne County, Va</u>		12. CITIZEN OF WHAT COUNTRY <u>U S</u>	
13. FATHER'S NAME <u>William James Henley</u>				14. MOTHER'S MAIDEN NAME <u>Emma Basier</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO <u>✓</u>		17. INFORMANT & ADDRESS <u>Mrs. Mary L. Heinemann</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
1a. IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 Hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Myocarditis</u>				<u>2 mos.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertensive disease</u>				<u>2 yrs.</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 1, 1953</u> to <u>28 Jan., 1956</u> , that I last saw the deceased alive on <u>28 Jan., 1956</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above							
SIGNATURE <u>J. Tyler Baker</u> M.D.				ADDRESS (Street, city, town, state) <u>Easton, Md.</u>		DATE SIGNED <u>29 Jan 56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>Jan 29 56</u>		NAME OF CEMETERY OR CREMATORY <u>Easton Home Chapel</u>		LOCATION (City, town, or county) (State) <u>Princess Anne County, Va</u>	
24. RECD BY REGISTRAR		REGISTRAR'S SIGNATURE <u>N.A. Neer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. L. Brock</u>		ADDRESS <u>Easton Md</u>	
DATE <u>Jan 29 56</u>							



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01038

1078

## CERTIFICATE OF DEATH

Reg. Dist. No. 291

1 PLACE OF DEATH COUNTY <u>talbot</u> MARYLAND CITY (If outside corporate limits, write RURAL LENGTH OF STAY OR (in this place) TOWN <u>Bellvue</u> <u>Life</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 17</u>		2 USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>talbot</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bellvue md.</u> STREET ADDRESS (If rural give location) <u>P.O. Box 17</u>	
3 NAME OF DECEASED (Type or Print) <u>Frank Easter Green</u> First (Middle) (Last)		4 DATE OF DEATH Month <u>1</u> Day <u>20</u> Year <u>1956</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>Col</u>	7 SINGLE MARRIED W DOWED DIVORCED (Specify): <u>married</u>	8 DATE OF BIRTH <u>6/12/1877</u>
9 AGE last birthday <u>68</u> yrs		10 MONTHS <u>6</u> Days <u>12</u> Hours <u>12</u> Min	
10A USUAL OCCUPATION (Give kind of work done during most of working life even if retired.) <u>waterman</u>		10B KIND OF BUSINESS OR INDUSTRY <u>Oyster</u>	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>George W. Green</u>		14 MOTHER'S MAIDEN NAME <u>Helen Brummel</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk. If Yes, give war or dates of service)		16 SOCIAL SECURITY NO.	
17 INFORMANT'S ADDRESS <u>Mrs Frank Green, Bellvue Md</u>			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>434.2</u> IMMEDIATE CAUSE ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (A) <u>Cardiac Asthma</u> DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A DATE OF OPERATION		19B MAJOR FINDINGS OF OPERATION	
20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B PLACE (Home, farm, factory, street, office bldg., etc.)	
21C WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D TIME (Month) (Day) (Year) (Hour) OF INJURY		21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/12, 1954</u> to <u>1/2, 1956</u> that I last saw the deceased alive on <u>12/25, 1955</u> and that death occurred at <u>130 AM</u> , from the causes and on the date stated above. SIGNATURE <u>Dr. Perkins</u> ADDRESS <u>M.D. Royal Oak Md</u> DATE SIGNED <u>15-56</u>			
23 BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Box 12</u>		DATE THEREOF <u>1/8/56</u> NAME OF CEMETERY OR CREMATORY <u>Royal oak Cem</u> LOCATION City, town, or county) (State) <u>Royal oak MD</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 7, 1956</u>		REGISTRAR'S SIGNATURE <u>Mrs. Ralsh. Suk</u> 24 FUNERAL DIRECTOR ADDRESS <u>James B. Darwell, Eastern Md</u>	

Dr. Perkins

U. S. A. J. 1911

1911

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

01039

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u> MARYLAND				STATE <u>MARYLAND</u> COUNTY <u>QUEEN ANNE'S</u>			
CITY If outside corporate limits, write RURAL LENGTH OF STAY OR and give nearest town) (in this place)				CITY If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>EASTON</u> 1 <u>14 days</u>				OR TOWN <u>INTERLOCK</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>EASTON MEMORIAL HOSP.</u>				STREET ADDRESS (If rural give location)			
3 NAME OF DECEASED (Type or Print)				4. DATE (Month) (Day) (Year)			
(First) (Middle) (Last)				OF DEATH			
<u>SARA</u> <u>HARRY</u>				<u>1</u> <u>13</u> <u>1956</u>			
5 SEX <u>F</u>		6 COLOR OR RACE <u>CAUCASIAN</u>		7 SINGLE MARRIED WIDOWED DIVORCED (Specify)		8 DATE OF BIRTH	
						9 AGE last birthday <u>71</u> yrs	
10A USUAL OCCUPATION Give kind of work done during most of working life. even if retired) <u>None</u>		10B KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country)		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Ryan</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Brown</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If Yes, give war or dates of service				16 SOCIAL SECURITY NO			
17 INFORMANT & ADDRESS <u>Edna Burns (Wife)</u>							
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Intra-cranial hemorrhage</u>							
ANTECEDENT CAUSE (B) <u>Coronary artery disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Hypertension</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A DATE OF OPERATION				19B. MAJOR FINDINGS OF OPERATION			
21A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B PLACE (Home, farm, factory, etc.) OF INJURY			
				21C WHERE DID INJURY OCCUR? City or town) (County) (State)			
21D TIME (Month) (Day) (Year) (Hour) OF INJURY				21E INJURY OCCURRED While at work Not while at work			
				21F HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>19</u> , to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>4:10</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Edna Burns</u>				DATE SIGNED <u>17 June 1956</u>			
23 BURIAL, CREMATION, REMOVAL (SPECIFY)				NAME OF CEMETERY OR CREMATORY			
<u>Burial</u>				<u>Wye Mills</u>			
DATE REC'D BY LOCAL REGISTRAR <u>1-14-56</u>				REGISTRAR'S SIGNATURE <u>W. H. Neer</u>			
				FUNERAL DIRECTOR <u>James D. Dahill</u>			
				ADDRESS <u>Baton, Md.</u>			

3 A 00000

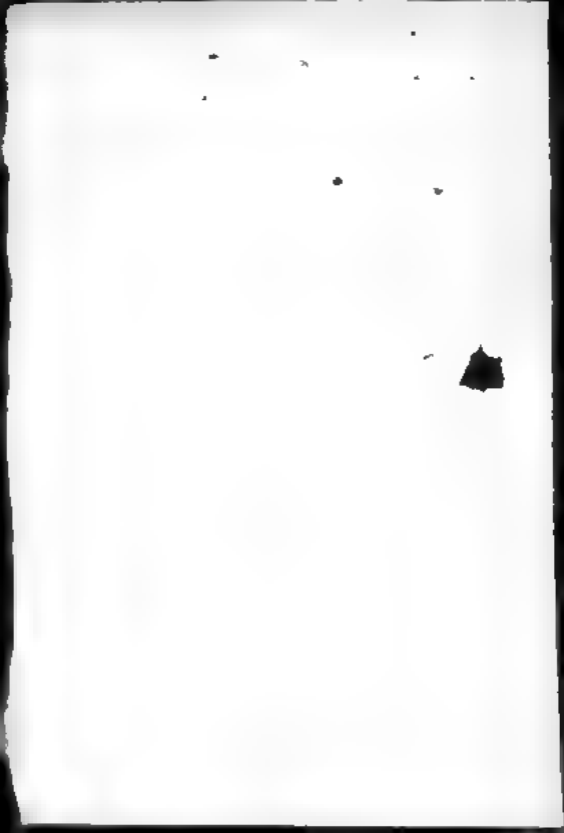
NY

2/11/50

2/11

This is all  
the information  
I have  
I have

Hammer of  
Memorial Hospital



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

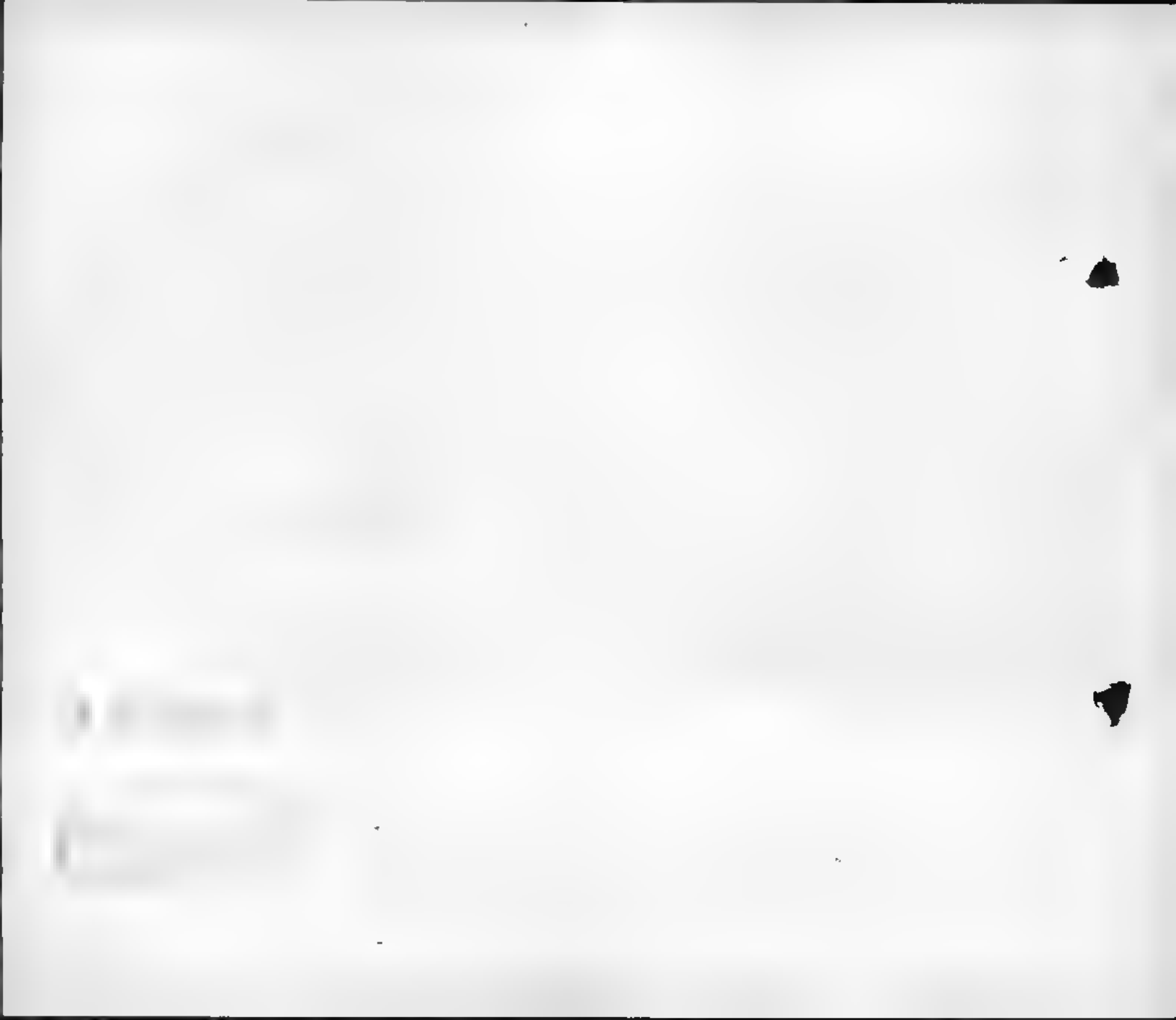
01040

1079

## CERTIFICATE OF DEATH

Reg. Dist. No. 291

1 PLACE OF DEATH COUNTY <u>Talbot</u> MARYLAND CITY If outside corporate limits, write RURAL LENGTH OF STAY OR <u>Royal Oak</u> <u>54 years</u> TOWN <u>Royal Oak</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS				2 USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Talbot</u> CITY If outside corporate limits, write RURAL and give nearest town) OR <u>Royal Oak</u> TOWN STREET ADDRESS (If rural give location)			
3 NAME OF DECEASED (Type or Print) <u>Fredrick</u> (Middle) <u>Harper</u> (Last) SEX <u>male</u> COLOR OR RACE <u>white</u> 7 SINGLE MARRIED <u>WIDOWED</u> 8 DATE OF BIRTH <u>Oct 2 1871</u> 9 AGE at birthday <u>84</u> yrs IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.				4 DATE (Month) (Day) (Year) OF DEATH <u>Jan. 15 1956</u>			
10A USUAL OCCUPATION (Give kind of work done a large part of working life.) <u>farmer</u> 10B KIND OF BUSINESS OR INDUSTRY: 11 BIRTHPLACE (State or foreign country) <u>Battle Creek Mich.</u> 12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13 FATHER'S NAME <u>John Harper</u> 14 MOTHER'S MAIDEN NAME <u>unknown</u>				15 WAS DECEASED EVER IN U.S. ARMED FORCES? Yes no, or unk. (If Yes, give war or dates of service) 16 SOCIAL SECURITY NO			
17 INFORMANT & ADDRESS <u>Mrs. Newman Callahan Belvidere Md.</u>							
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>myocardial infarction</u> DUE TO <u>6 hr</u>							
ANTECEDENT CAUSE (B) <u>arteriosclerotic coronary heart d.</u> DUE TO <u>-</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>abdominal aortic aneurysm</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19A DATE OF OPERATION		19B MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21B PLACE (Home, farm, factory, OF INJURY street, office bldg., etc)		21C WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-10 1956</u> to <u>1-15 1956</u> that I last saw the deceased alive on <u>1-15 1956</u> , and that death occurred at <u>6:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> ADDRESS <u>St Michaels Md.</u> DATE SIGNED <u>1-18-56</u>							
23 BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>Jan. 18, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Easton Md.</u>	
DATE REC'D BY LOCAL REG. STRA <u>Jan 18 1956</u>		REGISTRAR'S SIGNATURE <u>Mrs. Robert R. Beck</u>		FUNERAL DIRECTOR <u>Manuel C. Newman &amp; Son</u>		ADDRESS	



1060

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Talbot</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Calvert</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
TOWN <u>Easton</u>	<u>20 days</u>	TOWN <u>Calverton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Mrs. Susie Logan</u>		<u>1 22 1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>March 9 1875</u>
9. AGE last birthday <u>77</u> yrs.		10. AGE last birthday IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Tenkin</u>		14. MOTHER'S MAIDEN NAME: <u>Charlotte Taylor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Mrs. Claude L. Logansall son Greenville Delaware</u>	
16. SOCIAL SECURITY NO			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
(A) IMMEDIATE CAUSE		<u>2 months</u>	
(B) ANTECEDENT CAUSE (S)		<u>?</u>	
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION.		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>1/2</u> , 1956, to <u>1/22</u> , 1956, that I last saw the deceased alive on <u>1/22</u> , 1956, and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.		23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u> DATE THEREOF <u>1/25/56</u> NAME OF CEMETERY OR CREMATORY <u>Parsons</u> LOCATION (City, town, or county) (State) <u>Salisbury Md</u>	
24. FUNERAL DIRECTOR ADDRESS <u>George C. Thye Salisbury, Md</u>			
DATE REC'D BY LOCAL REGISTRAR <u>1/23/56</u> REGISTRAR'S SIGNATURE <u>N. H. Neer</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S. A. C. 1000

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1059

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Talbot</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Queen Anne's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	LENGTH OF STAY (In this place) <u>1 day</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) <u>James</u> (Middle) <u>B</u> (Last) <u>Hess</u>		4. DATE OF DEATH: (Month) <u>1</u> (Day) <u>20</u> (Year) <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> (Specify)	8. DATE OF BIRTH <u>June 28, 1869</u>
		9. AGE last birthday <u>86</u> yrs	10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired).	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME: <u>James B Hess</u>		14. MOTHER'S MAIDEN NAME: <u>Anna Marie Friel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS <u>Mrs Clara C. Kuntal</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Heart failure</u>			
ANTECEDENT CAUSE (B) <u>Arteriosclerosis</u>			
DISEASES OR CONDITIONS IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST			
(C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE Home, farm, factory OF INJURY street, office bldg., etc	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>May 1</u>	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1/9</u> , 19 <u>56</u> , to <u>1/20</u> , 19 <u>56</u> that I last saw the deceased alive on <u>1/20</u> , 19 <u>56</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		ADDRESS <u>[Signature]</u>	DATE SIGNED <u>2/4/56</u>
23. BURIAL CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>1/23/56</u>	NAME OF CEMETERY OR CREMATORY <u>St. Peter's</u>	LOCATION (City, town or county) <u>Queenstown</u> State <u>MD</u>
DATE REC'D BY LOCAL REGISTRAR <u>1/20/56</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>Barton Ben Crumple</u>	ADDRESS <u>Maryland</u>

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Nv!

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01043

1961

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Talbot</u> MARYLAND				STATE <u>md</u> COUNTY <u>Talbot</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> LENGTH OF STAY <u>1 1/2 days</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bellevue</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Robert Johnson</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>Jan. 1 1956</u>			
5. SEX <u>Male</u> COLOR OR RACE <u>Black</u> SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>				6. DATE OF BIRTH <u>Jan 10 1896</u> 59 yrs. Months Days Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Palmer</u>				11. BIRTHPLACE (State or foreign country) <u>Virginia</u>			
13. FATHER'S NAME <u>Alec Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Sallie Carter</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO			
17. INFORMANT & ADDRESS <u>Martha Johnson (wife)</u>				18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
(IMMEDIATE CAUSE) (A) DUE TO <u>Apoplexy</u>				<u>1 day</u>			
(ANTECEDENT CAUSE) (B) DUE TO <u>H.C.V.D.</u>				<u>?</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory of INJURY street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? City or town: (County) (State)							
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from <u>12/30/1955</u> to <u>1/1/1956</u> that I last saw the deceased alive on <u>Jan. 1</u> , 1956, and that death occurred at <u>8:15 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>1-1-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>1-3-56</u>			
NAME OF CEMETERY OR CREMATORY <u>Bellevue</u>				LOCATION (City town or county) (State) <u>Bellevue md</u>			
DATE REC'D BY LOCAL REGISTRAR <u>1-2-56</u>				24. FUNERAL DIRECTOR ADDRESS <u>[Signature]</u>			

U. S. A.

1941

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01044

1062

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1 PLACE OF DEATH COUNTY <u>TALBOT</u> MARYLAND CITY (if outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Easton</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>		2 USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Queen Anne's</u> CITY (if outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Stevensville</u> STREET ADDRESS (if rural give location)	
3 NAME OF DECEASED (Type or Print) <u>Kelly</u>	(First) (Middle) (Last) <u>Kelly Jr</u>	4 DATE (Month) (Day) (Year) OF DEATH <u>1</u> <u>8</u> <u>1956</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 SINGLE MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8 DATE OF BIRTH <u>December 31, 1903</u>
9 AGE last birthday <u>52</u> yrs		10 IF UNDER 1 YEAR IF UNDER 24 Mos Months Days Hours Min.	
10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Medical Officer</u>		10B KIND OF BUSINESS OR INDUSTRY <u>MD. House Correction</u>	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Mr. James Kelly, Sr.</u>		14 MOTHER'S MAIDEN NAME <u>Adeline Thomas</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16 SOCIAL SECURITY NO.	
17 INFORMANT & ADDRESS <u>Mrs. Marie Kelly</u>		18 MEDICAL CERTIFICATION	
1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> IMMEDIATE CAUSE ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST		(A) DUE TO <u>Myocardial Infarct</u> <u>Coronary thrombosis</u> (B) DUE TO (C)	
19 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19A DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION		20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21B PLACE (Home, farm, factory, office bldg, etc)	21C WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D TIME (Month) (Day) (Year) (Hour) OF INJURY	21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12:30</u> , 19 <u>56</u> , to <u>1:00</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12:30</u> , 19 <u>56</u> , and that death occurred at <u>4:20</u> AM, from the causes and on the date stated above. SIGNATURE <u>[Signature]</u> M.D. <u>Easton</u> DATE SIGNED <u>8 Jan 1956</u>			
23 BURIAL CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>Jan 11, 1956</u>	NAME OF CEMETERY OR CREMATORY <u>Stevensville Md.</u>	LOCATION (City, town, or county) (State) <u>Stevensville, MD</u>
DATE REC'D BY LOCAL REGISTRAR <u>1-2-56</u>	REGISTRAR'S SIGNATURE <u>M. H. Newkirk</u>	24 FUNERAL DIRECTOR <u>[Signature]</u>	ADDRESS <u>Stevensville, Md.</u>

BUREAU V. B.

JAN 17 1956

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN** The law requires that the death certificate be filed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10A

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

01045

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <del>Talbot</del> Talbot		MARYLAND		STATE Maryland		COUNTY Talbot	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Easton				TOWN St. Michaels,			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital, Easton, Md.				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First, Middle, Last)				4. DATE OF DEATH (Month, Day, Year)			
Charles Kiehl				1 6 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS
M	W	Married	3/17/1872	83 yrs	Months	Days	Hours Min
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Hotel Owner			Hotel	Germany		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
George K. Kiehl				Katherine Schmoll			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No.				Memorial Hospital, Easton, Md.			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) Carcinoma-generalized-metastatic				INTERVAL BETWEEN ONSET AND DEATH 2 yrs			
ANTECEDENT CAUSE(S) DUE TO (B) carcinoma-prostate-adenocarcinoma				2 + yrs			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST DUE TO (C)							
18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Generalized cachexia							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month, Day, Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7-26, 1956, to 1-6, 1956, that I last saw the deceased alive on 1-6, 1956, and that death occurred at 9:00 PM, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
[Signature]				St. Michaels, Md.		1-7-56	
23. BURIAL, CREMATION, REMOVAL, SPECIFY		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		1/10/56		Willdwood		Williamsport Penna.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 11		[Signature]		[Signature]		St. Michaels, Md.	

3 A 0000

1080

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01046

## CERTIFICATE OF DEATH

Reg. Dist. No. 291

## 1. PLACE OF DEATH

COUNTY TALBOT

MARYLAND

CITY If outside corporate limits, write RURAL LENGTH OF STAY  
OR and give nearest town) (in this place)X TOWN ST. MICHAELS25 YEARSHOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

## 2 USUAL RESIDENCE (HOME) OF DECEASED

STATE MDCOUNTY TalbotCITY (If outside corporate limits, write RURAL and give nearest town)  
ORTOWN St. MichaelsSTREET  
ADDRESS Grace St

(If rural give location)

3 NAME OF  
DECEASED

(Type or Print)

(First)

SAMUEL

(Middle)

WILLARD

(Last)

LEGG

## 4. DATE (Month) (Day) (Year)

OF

DEATH

JAN

(Day)

13

(Year)

1956

## 5. SEX

MALE

## 6 COLOR OR 7 SINGLE, MARRIED

WHITE

## W. DOWED, DIVORCED

SINGLE

## 8 DATE OF BIRTH

APRIL 11, 1900

## 9 AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

55 yrs

Months

Days

Hours

Min

## 10A USUAL OCCUPATION (Give kind of work done during most of working life even if retired)

TAXI DRIVER

## 10B KIND OF BUSINESS OR INDUSTRY

## 11 BIRTHPLACE (State or foreign country):

St. MICHAELS MD

## 12 CITIZEN OF WHAT COUNTRY?

USA

## 13 FATHER'S NAME

WILLIAM B LEGG

## 14 MOTHER'S MAIDEN NAME

ELIZABETH MYERS

## 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

## 16 SOCIAL SECURITY NO.

220-16-9752

## 17. INFORMANT &amp; ADDRESS

Mrs. Mary Wright Sherwood MD

## 18. MEDICAL CERTIFICATION

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

## IMMEDIATE CAUSE

## ANTECEDENT CAUSE (S)

## DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

260X

## (A)

Myocardial Infarction

DUE TO

(B)

arteriosclerotic coronary heart d

DUE TO

(C)

## 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH

Diabetes Mellitus

## INTERVAL BETWEEN ONSET AND DEATH

10 hrs.

## 19A DATE OF OPERATION:

## 19B MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

## 21B PLACE (Home, farm, factory OR INJURY street, office bldg., etc

## 21C. WHERE DID (City or town) (County) (State)

## 21D TIME (Month) (Day) (Year) (Hour) OF INJURY

## 21E INJURY OCCURRED

White ☐ Not white ☐at work ☐ at work ☐

## 21F HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-20, 1952 to 1-13, 1956 that I last saw the deceasedalive on 1-13, 1956 and that death occurred at 7:30 PM, from the causes and on the date stated above.

SIGNATURE OF

ADDRESS

DATE SIGNED

## 23 BURIAL CREMATION REMOVAL (SPECIFY)

Burial

## DATE THEREOF

Jan 16/ 1956

## NAME OF CEMETERY OR CREMATORY

Older Cemetery

## LOCATION City, town, or county

St. Michaels MD

## (State)

## DATE REC'D BY LOCAL REGISTRAR

1-16-56

## REGISTRAR'S SIGNATURE

Mrs. G. H. R. Bell

## 24 FUNERAL DIRECTOR

W. Hamilton Harrison

## ADDRESS

St. Michaels MD

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 11

BUREAU V. S.

1964

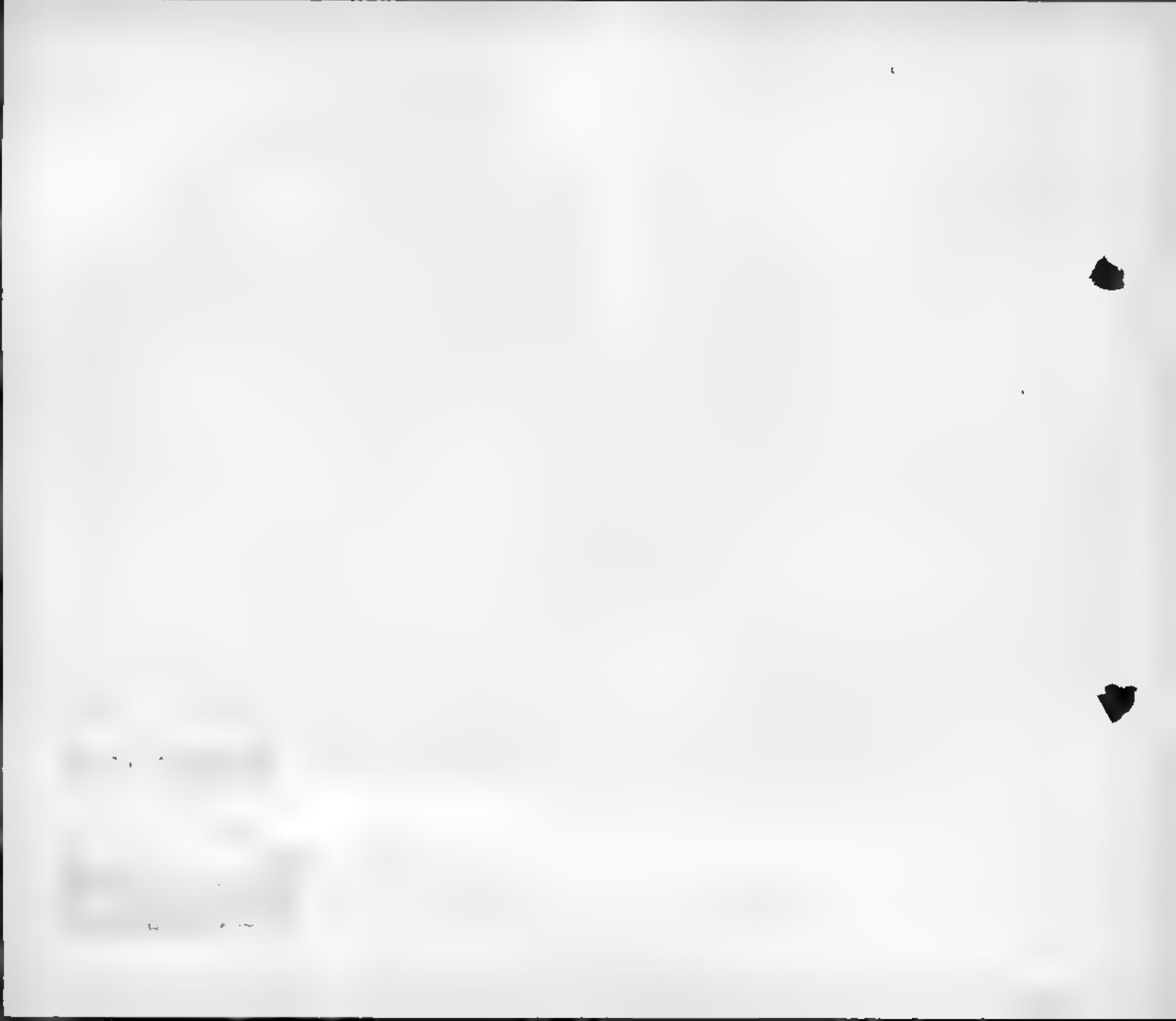
## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1 PLACE OF DEATH		2 USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Lake</i>	MARYLAND	STATE <i>Maryland</i> COUNTY <i>Lake</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>	
TOWN <i>Easton</i>		OR TOWN <i>Easton</i>	
3 HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <i>465 North St</i>	
4 NAME OF DECEASED (Type or Print) <i>James Marshall</i>		4 DATE (Month) (Day) (Year) <i>Dec 25 1958</i>	
5 SEX <i>male</i>	6 COLOR OR RACE <i>White</i>	7 SINGLE MARRIED <i>Married</i>	8 DATE OF BIRTH <i>May 8, 1889</i>
9 AGE (In years, months, days, hours, minutes) <i>66 yrs</i>	10 UNDER 1 YEAR <i>Months</i>	11 UNDER 24 HRS <i>Days</i>	12 UNDER 24 HRS <i>Hours</i>
10A USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) <i>Farmer</i>	10B KIND OF BUSINESS OR INDUSTRY <i>Food Sales</i>	11 BIRTHPLACE (State or foreign country) <i>Maryland (Lake Co)</i>	12 CITIZEN OF WHAT COUNTRY? <i>US</i>
13 FATHER'S NAME <i>James A. Marshall</i>		14 MOTHER'S MAIDEN NAME <i>Martha E. Paul</i>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16 SOCIAL SECURITY NO. <i>218-01-8632</i>	
17 INFORMANT & ADDRESS <i>Edward Marshall</i>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE <i>Coronary Thrombosis</i>		<i>Sudden</i>	
(B) ANTECEDENT CAUSE (S) <i>Coronary atherosclerosis</i>		<i>3-4</i>	
(C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <i>Heart disease</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19A DATE OF OPERATION. <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (If either notify medical examiner)		21B PLACE (Home, farm, factory, street, office bldg., etc.)	
21C WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D TIME (Month) (Day) (Year) (Hour) OF INJURY		21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1958</i> , 19 <i>to 25th</i> , 19 <i>1962</i> , that I last saw the deceased alive on <i>12-25</i> , 19 <i>1958</i> , and that death occurred at <i>M. from the causes and on the date stated above.</i>			
23 BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>Jan 28, 1964</i>	
NAME OF CEMETERY OR CREMATORY <i>Spring Hill Cemetery</i>		LOCATION (If in town or county, (State) <i>Lake Co, Maryland</i>	
DATE REC'D BY LOCAL REGISTRAR <i>1-26-64</i>		REGISTRAR'S SIGNATURE <i>N. H. Neerew</i>	
24 FUNERAL DIRECTOR <i>Lawrence E. Neerew</i>		ADDRESS <i>Neerew &amp; Son</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1965

## CERTIFICATE OF DEATH

Reg. Dist. No. 290...

## 1. PLACE OF DEATH:

COUNTY Talbot MARYLAND  
 CITY OR TOWN Easton LENGTH OF STAY 2 days  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Talbot  
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Foster  
 STREET ADDRESS (If rural give location)

## 3. NAME OF DECEASED:

(First) Catherine (Middle) Martha (Last) 1

4. DATE (Month) (Day) (Year)  
 OF DEATH 1 19 1956

## 5. SEX.

Female

COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH June 7, 1868

9. AGE last birthday 87 yrs

10. UNDER 1 YEAR 11. UNDER 24 HRS. 12. UNDER 24 HRS. Months Days Hours Min.

10A. USUAL OCCUPATION Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country) Ireland

12. CITIZEN OF WHAT COUNTRY? US citizen

## 13. FATHER'S NAME

Michael Corroy

## 14. MOTHER'S MAIDEN NAME

Anne Haddy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

## 17. INFORMANT'S ADDRESS

Mrs. Helen Evers (daughter)  
Easton, Md.

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## IMMEDIATE CAUSE

(A) MYOCARDIAL RUPTURE

INTERVAL BETWEEN ONSET AND DEATH

Instant

## ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

(B) Acute MYOCARDIAL INFARCTION

48 hours

(C) Arteriosclerotic + Hypertensive H.C., 12 years

12 years

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION

## 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either notify medical examiner)

21B. PLACE Home, farm, factory OF INJURY street, office bldg., etc

21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from

alive on 1-19, 1956, and that death occurred at 4:12 AM, from the causes and on the date stated above.

SIGNATURE

Shoemaker

M. D.

ADDRESS

Easton

DATE SIGNED

1/24/56

23. BURIAL, CREMATION, DATE THEREOF REMOVAL (SPECIFY)

NAME OF CEMETERY OR CREMATORY

LOCATION (City town or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

1/20/56

N.H. Nixson

Easton

Easton

MARGIN RESERVED FOR BINDING



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01049

1066

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1 PLACE OF DEATH COUNTY <u>HARFORD</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>REESICK</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>LASER MEMORIAL HOSP</u>		2 USUAL RESIDENCE (HOME) OF DECEASED. STATE <u>Maryland</u> COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>REESICK</u> STREET ADDRESS (If rural give location)	
3 NAME OF DECEASED. (Type or Print) <u>Agostia B. March</u> First (Middle) (Last)		4 DATE (Month) (Day) (Year) OF DEATH <u>1</u> <u>13</u> <u>1956</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>White</u>	7 SINGLE MARRIED WIDOWED DIVORCED (Specify)	8 DATE OF BIRTH <u>March 13 1894</u>
9 AGE last birthday <u>66</u> yrs		10 AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). <u>None</u>		10B KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13 FATHER'S NAME <u>William Jones Parker</u>		14 MOTHER'S MAIDEN NAME <u>Leann Jones</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.) <u>No</u> (If Yes, give war or dates of service)		16 SOCIAL SECURITY NO <u>None</u>	
17 INFORMANT & ADDRESS <u>Mrs. Naomi B. Parker</u>		18 MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>Apoplexy in situ</u> ANTECEDENT CAUSE (B) <u>arteriosclerosis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST (C) <u>atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 1/2</u>	
19 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A DATE OF OPERATION: <u>1</u>		19B MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B PLACE Home farm factory of INJURY street, office bldg., etc.	
21C WHERE DID (City or town) (County) (State)		21D HOW DID INJURY OCCUR?	
21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>1954</u> to <u>1/13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/13</u> , 19 <u>56</u> , and that death occurred at <u>6:15</u> A.M., from the causes and on the date stated above. SIGNATURE <u>Edna M. Harrison</u> ADDRESS <u>Carters Maryland</u> DATE SIGNED <u>12/15/56</u> M.D.			
23 BURIAL CREMATION REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/15/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Portsmouth Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/14/56</u>		REGISTRAR'S SIGNATURE <u>W. H. Harrison</u>	
24 FUNERAL DIRECTOR <u>Barton Ben. Osterman</u>		ADDRESS <u>Frederick, Maryland</u>	

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN & HOSPITAL:** The law requires that the death certificate be filed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

01056

Reg. Dist. No.

291

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Talbot		MARYLAND		STATE St. Maryland		COUNTY Talbot	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN St. Michaels		Life		TOWN St. Michaels			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
William J. Mitchell				1 9 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
M	Colored	Married	11/14/1875	80 yrs.	Months	Days	Hours
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Laborer		Waterman		St. Michaels, Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Samuel Mitchell				Katherine Green			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		217-03-6108		+ Louise Mitchell			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A)				Myocardial infarction			
ANTECEDENT CAUSE(S) DUE TO				arteriosclerotic coronary heart d.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST DUE TO (C)							
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				6 hrs			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg. etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from 3-15 1954, to 1-9 1956, that I last saw the deceased alive on 1-9 1956, and that death occurred at 1:45 P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
1-9-56				St. Michaels md 1-9-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		1/11/56		New St. Michaels Cemetery		St. Michaels, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		Mrs. R. J. Jones		Norman L. Marshall		St. Michaels, Md.	
DATE							



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INSTRUCTIONS

The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01051

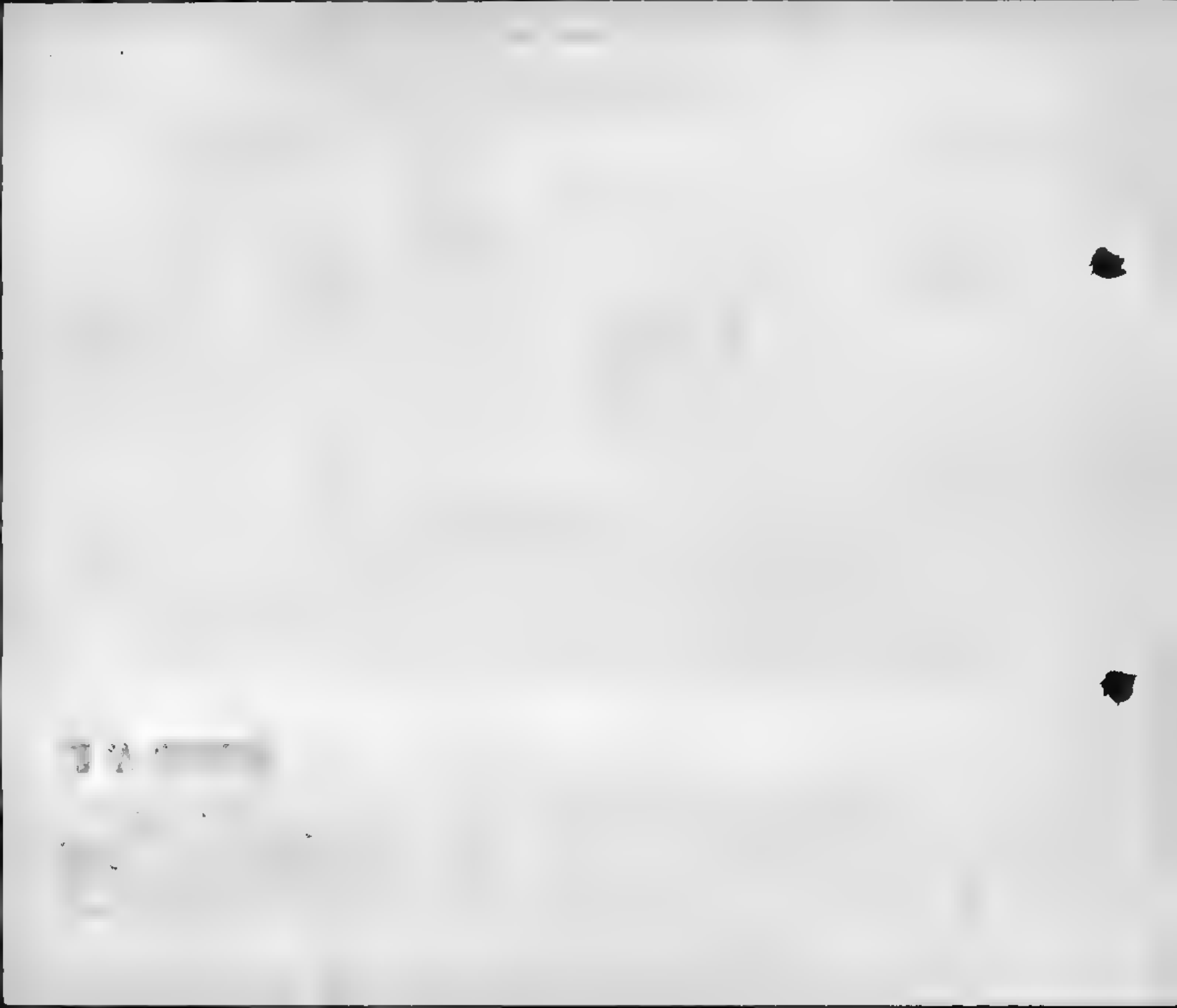
1082

## CERTIFICATE OF DEATH

Item 2, Filmday 1-12-56 at

Reg. Dist. No. 291

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Talbot</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Talbot</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Tilghman</i>		<i>7 yrs</i>		TOWN <i>Tilghman</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<i>Sherrwood Md</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<i>George Peoples</i>				<i>Jan 9 1956</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS	
<i>Male</i>	<i>Col.</i>	<i>Single</i>	<i>Dec 25, 1913</i>	<i>42 yrs.</i>	Months	Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Butcher</i>		<i>Farm</i>		<i>Skippers Va</i>		<i>U.S.A.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>James Peoples</i>				<i>Rutha Carpenter</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unk.)		16. SOCIAL SECURITY NO		17. INFORMANT & ADDRESS			
<i>No.</i>		<i>228-05-1160</i>		<i>James L. Peoples - Sherrwood Md.</i>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<i>420.1</i>				<i>Coronary occlusion</i>			
IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from ... 19... to ... 19... that I last saw the deceased alive on ... 1955, and that death occurred at ... AM, from the causes and on the data stated above.							
SIGNATURE				DATE SIGNED			
<i>George Peoples</i>				<i>Jan 9 1956</i>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION City, town, or county (State)	
<i>V</i>		<i>Jan 12/56</i>		<i>Diamond Grove</i>		<i>Skippers Greenbelt Co, Va</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<i>Mrs. L. L. Lath</i>		<i>Thomas D. Marshall</i>		<i>St Michael's</i>	
DATE							



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01052

1967

## CERTIFICATE OF DEATH

Reg. Dist. No 290

1 PLACE OF DEATH				2 USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Easton</u>		<u>11 days</u>		TOWN <u>Easton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>31 S. Main St.</u>			
3 NAME OF DECEASED (Type or Print) <u>Nannie Poilouch</u>				4 DATE OF DEATH (Month) <u>1</u> (Day) <u>14</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>		6 COLOR OR RACE <u>Cauc.</u>		7 SINGLE MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8 DATE OF BIRTH <u>Nov-1894</u>	
9 AGE last birthday <u>61</u> yrs				10 AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min			
10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13 FATHER'S NAME <u>Simon Beck</u>				14 MOTHER'S MAIDEN NAME <u>Kamari Chapman</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16 SOCIAL SECURITY NO			
17 INFORMANT'S ADDRESS <u>Class Stanley</u>							
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Hemorrhage, left cerebrum.</u>							
ANTECEDENT CAUSE (B) <u></u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u></u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19A DATE OF OPERATION				19B MAJOR FINDINGS OF OPERATION			
20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B PLACE (Home, farm, factory, etc) OF INJURY			
21C WHERE DID INJURY OCCUR? (City or town) County) (State)							
21D TIME (Month) (Day) (Year) (Hour) OF INJURY				21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
21F HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from <u>1/13</u> , 1956, to <u>1/14</u> , 1956 that I last saw the deceased alive on <u>1/13</u> , 1956, and that death occurred at <u>5:05 PM</u> , from the causes and on the date stated above							
SIGNATURE <u>Ed Schmidt</u>				DATE SIGNED <u>17 Jan 1956</u>			
23 BURIAL CREMATION, REMOVAL (Specify) <u>Buried</u>				DATE THEREOF <u>1/17/56</u>			
NAME OF CEMETERY OR CREMATORY <u>Richard</u>				LOCATION (City, town, or county) <u>Easton Md</u>			
DATE REC'D BY LOCAL REGISTRAR <u>1/16/56</u>				REGISTRAR'S SIGNATURE <u>N-H. Neer</u>			
24 FUNERAL DIRECTOR <u>Samuel B. White</u>				ADDRESS <u>Easton, Md</u>			

3. A. C. 1952.

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1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01053

1068

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH.  |  |  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED                                 |  |  |  |
| COUNTY <u>Talbot</u>  |  | MARYLAND   |  | STATE <u>Maryland</u> COUNTY <u>Talbot</u>                            |  |  |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)   |  | LENGTH OF STAY (in this place)   |  | CITY (If outside corporate limits, write RURAL and give nearest town) |  |  |  |
| TOWN <u>Easton</u>  |  | <u>12 days</u>   |  | OR TOWN <u>Easton</u>   |  |  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial</u>   |  |  |  | STREET ADDRESS (If rural give location)                               |  |  |  |
| 3. NAME OF DECEASED: (First) (Middle) (Last)  |  |  |  | 4. DATE (Month) (Day) (Year)  |  |  |  |
| DECEASED: <u>George R. Powderhill</u>   |  |  |  | OF DEATH <u>1</u> <u>14</u> <u>1956</u>                               |  |  |  |
| 5. SEX <u>M</u>   |  | 6. COLOR OR RACE: <u>W</u>   |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):                     |  | 8. DATE OF BIRTH.  |  |
|   |  |  |  |   |  | <u>May 22, 1885</u>  |  |
|   |  |  |  | 9. AGE last birthday <u>70</u> yrs.                                   |  | 10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.                     |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired).  |  |  |  | 10B. KIND OF BUSINESS OR INDUSTRY                                     |  | 11. BIRTHPLACE (State or foreign country):                                       |  |
|   |  |  |  |   |  | <u>Penna.</u>  |  |
| 13. FATHER'S NAME   |  |  |  | 14. MOTHER'S MAIDEN NAME  |  |  |  |
| <u>Mr. Thomas Powderhill</u>  |  |  |  | <u>Mary Heinlein</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service)  |  |  |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT & ADDRESS  |  |
|   |  |  |  |   |  | <u>Mrs. Margaret Powderhill</u>  |  |
| 18. MEDICAL CERTIFICATION   |  |  |  |   |  |  |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (A)   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH                                      |  |  |  |
| <u>Hemorrhage</u>   |  |  |  |   |  |  |  |
| ANTECEDENT CAUSE (B)  |  |  |  |   |  |  |  |
| <u>Aneurism of pancreas duct</u>  |  |  |  |   |  |  |  |
| DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.  |  |  |  |   |  |  |  |
| (C)   |  |  |  |   |  |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH   |  |  |  |   |  |  |  |
| 19A. DATE OF OPERATION  |  | 19B. MAJOR FINDINGS OF OPERATION   |  |   |  |  |  |
|   |  |  |  |   |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)  |  | 21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc)                                   |  | 21C. WHERE DID INJURY OCCUR? (City or town, (County) (State)          |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
|   |  |  |  |   |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |  |  |
|   |  |  |  |   |  |  |  |
| 22. I hereby certify that I attended the deceased from <u>1956</u> , to <u>1956</u> , that I last saw the deceased alive on <u>10<sup>th</sup></u> <u>1956</u> , and that death occurred at <u>10<sup>th</sup></u> <u>1956</u> M. from the causes and on the date stated above. |  |  |  |   |  |  |  |
| SIGNATURE <u>Pathologist</u>  |  | M. D. <u>Carlson</u>   |  | DATE SIGNED <u>17 Jan 1956</u>  |  |  |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | DATE THEREOF   |  | NAME OF CEMETERY OR CREMATORY   |  | LOCATION (City, town or county) (State)  |  |
| <u>BURIAL</u>   |  | <u>JAN. 17, 1956</u>   |  | <u>SPRING HILL CEMETERY</u>   |  | <u>EASTON, MD.</u>   |  |
| DATE REC'D BY LOCAL REGISTRAR   |  | REGISTRAR'S SIGNATURE  |  | 24. FUNERAL DIRECTOR  |  | ADDRESS  |  |
| <u>1/16/56</u>  |  | <u>N. H. Neeruss</u>   |  | <u>W. Hampton Powell</u>  |  | <u>Easton, MD.</u>   |  |



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians' please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01054

1063

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1 PLACE OF DEATH   |  |  |  | 2 USUAL RESIDENCE (HOME) OF DECEASED   |  |  |  |
| COUNTY <u>Talbot</u> MARYLAND<br>CITY (If outside corporate limits, write RURAL, and give nearest town) <u>Easton</u><br>TOWN <u>25 days</u><br>HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial</u>  |  |  |  | STATE <u>Md.</u> COUNTY <u>Talbot</u><br>CITY (If outside corporate limits, write RURAL, and give nearest town) OR TOWN <u>St Michaels Md.</u><br>STREET ADDRESS (If rural give location) <u>—</u> |  |  |  |
| 3 NAME OF DECEASED (Type or Print)   |  |  |  | 4 DATE (Month, Day, Year) OF DEATH   |  |  |  |
| (First) <u>Agnes</u> (Middle) <u>Roberts</u> (Last) <u>Roberts</u><br>SEX <u>Female</u> COLOR OR RACE <u>Col.</u> SINGLE <u>Married</u> MARRIED <u>Divorced</u> WIDOWED <u>Divorced</u> DIVORCED (Specify) <u>Mar 9, 1876</u>  |  |  |  | 9 AGE last birthday <u>79</u> yrs. 10 UNDER 1 YEAR 11 UNDER 24 HRS<br>12 CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  |  |  |
| 5 SEX  |  |  |  | 8 DATE OF BIRTH  |  |  |  |
| 10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  |  |  | 11 BIRTHPLACE (State or foreign country)   |  |  |  |
| 10B KIND OF BUSINESS OR INDUSTRY   |  |  |  | 12 CITIZEN OF WHAT COUNTRY?  |  |  |  |
| 13 FATHER'S NAME   |  |  |  | 14 MOTHER'S MAIDEN NAME  |  |  |  |
| <u>Moses Roberts</u>   |  |  |  | <u>Priscilla Adams</u>   |  |  |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service)  |  |  |  | 16 SOCIAL SECURITY NO  |  |  |  |
| 17 INFORMANT & ADDRESS   |  |  |  | 18 MEDICAL CERTIFICATION   |  |  |  |
| 19A DATE OF OPERATION  |  |  |  | 19B MAJOR FINDINGS OF OPERATION  |  |  |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21B. PLACE (Home farm factory of INJURY street, office bldg., etc)   |  |  |  |
| 21C. WHERE DID (City or town) (County) (State)   |  |  |  | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  |  |  |
| 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  | 21F. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I hereby certify that I attended the deceased from <u>12/22</u> , 19 <u>54</u> , to <u>1/18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/18</u> , 19 <u>56</u> , and that death occurred at <u>30</u> AM, from the causes and on the date stated above. |  |  |  |  |  |  |  |
| 23 BURIAL CREMATION, REMOVAL (Specify)   |  |  |  | 24 FUNERAL DIRECTOR ADDRESS  |  |  |  |
| DATE REC'D BY LOCAL REGISTRAR <u>1/19/56</u><br>REGISTRAR'S SIGNATURE <u>N. H. Mercer</u><br>NAME OF CEMETERY OR CREMATORY <u>St. Michaels</u><br>LOCATION (City, town or county) (State) <u>St. Michaels Md</u>   |  |  |  | DATE SIGNED <u>1-23-56</u><br>ADDRESS <u>M. D. St. Michaels</u>  |  |  |  |



AN

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1970 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01055

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH. <u>GI 92 2-1-5 L</u>  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED  |  |
| COUNTY <u>Talbot</u>   | MARYLAND                                     | STATE <u>Maryland</u>  | COUNTY <u>Talbot</u>                   |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton, Md.</u>   | LENGTH OF STAY (in this place) <u>9 days</u> | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Easton</u>  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hospital</u>  |  | STREET ADDRESS (If rural give location) <u>129 S. Washington St.</u>   |  |
| 3. NAME OF DECEASED (First) <u>William</u> (Middle) <u>THEODORE</u> (Last) <u>Robinson</u>   |  | 4. DATE (Month) (Day) (Year) OF DEATH <u>1 - 30 - 1956</u>   |  |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u>                | 7. SINGLE MARRIED, WIDOWED DIVORCED (Specify) <u>married</u>   | 8. DATE OF BIRTH <u>March 29, 1872</u> |
| 9. AGE last birthday <u>83</u> yrs   |  | 10. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Capt. U.S. Army</u>   |  | 10B. KIND OF BUSINESS OR INDUSTRY <u>U.S. Army</u>   |  |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 13. FATHER'S NAME: <u>Theodore F. Robinson</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Helen N. Watkins</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMATION & ADDRESS: <u>Mrs. Alice Robinson (Wife)</u>   |  |  |  |
| 18. MEDICAL CERTIFICATION  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  |  |  |
| (A) IMMEDIATE CAUSE <u>Coronary Heart Failure</u>  |  | <u>3 mos.</u>  |  |
| (B) ANTECEDENT CAUSE (S) <u>Arteriosclerotic heart disease</u>   |  | <u>years</u>   |  |
| (C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST   |  |  |  |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH   |  |  |  |
| 19A. DATE OF OPERATION:  |  | 19B. MAJOR FINDINGS OF OPERATION   |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21B. PLACE (Home, farm, factory OF INJURY street, office bldg etc  |  |
| 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?   |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  |
| 21F. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I hereby certify that I attended the deceased from <u>Aug 1952</u> , to <u>Jan 2, 1956</u> , that I last saw the deceased alive on <u>1-30</u> , 1956, and that death occurred at <u>1:50</u> M, from the causes and on the date stated above. |  |  |  |
| SIGNATURE <u>Donald A. Bentley M.D.</u>  |  | DATE SIGNED <u>1-30-56</u>   |  |
| 23. BURIAL CREMATION, DATE THEREOF <u>Feb. 2, 1956</u>   |  | NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>   |  |
| LOCATION (City town, or county) <u>Annapolis Md</u>  |  | (State) <u>Md</u>  |  |
| DATE REC'D BY LOCAL REGISTRAR <u>1-30-56</u>   |  | REGISTRAR'S SIGNATURE <u>N.A. Neer</u>   |  |
| FUNERAL DIRECTOR <u>M.E. Newnam</u>  |  | ADDRESS <u>109 Easton</u>  |  |

1911

1912

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01056

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

|  |  |                          |  |   |  |                                     |  |
|--|--|--------------------------|--|---|--|-------------------------------------|--|
| 1 PLACE OF DEATH   |  |                          |  | 2 USUAL RESIDENCE (HOME) OF DECEASED  |  |                                     |  |
| COUNTY <u>Talbot</u> MARYLAND  |  |                          |  | STATE <u>Maryland</u> COUNTY <u>Talbot</u>  |  |                                     |  |
| CITY <u>Easton</u> (If outside corporate limits, write RURAL and give nearest town)  |  |                          |  | CITY <u>Easton</u> (If outside corporate limits, write RURAL and give nearest town)   |  |                                     |  |
| TOWN <u>Easton</u>   |  |                          |  | TOWN <u>Easton</u>  |  |                                     |  |
| HOSPITAL OR INST TUT ON OR STREET ADDRESS <u>Memorial Hospital</u>   |  |                          |  | STREET ADDRESS (If rural give location) <u>R 7 D #4</u>   |  |                                     |  |
| 3 NAME OF DECEASED (Type or Print, (First) (Middle) (Last)) <u>Joseph D Spencer</u>  |  |                          |  | 4 DATE OF DEATH (Month) (Day) (Year) <u>1 9 1956</u>  |  |                                     |  |
| 5 SEX <u>M</u>   |  | 6 COLOR OR RACE <u>W</u> |  | 7 SINGLE MARRIED WIDOWED DIVORCED <u>WIDOWED</u>  |  | 8 DATE OF BIRTH <u>Oct 26, 1889</u> |  |
| 9 AGE last birthday <u>66</u> yrs  |  | 10 MONTHS <u>66</u>      |  | 11 DAYS <u>66</u>   |  | 12 HOURS <u>66</u>                  |  |
| 10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>   |  |                          |  | 10B KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>  |  |                                     |  |
| 11 BIRTHPLACE (State or foreign country) <u>Maryland</u>   |  |                          |  | 12 CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |                                     |  |
| 13 FATHER'S NAME: <u>Mr Alexander Spencer</u>  |  |                          |  | 14 MOTHER'S MAIDEN NAME: <u>Mary Eason</u>  |  |                                     |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service)  |  |                          |  | 16 SOCIAL SECURITY NO   |  |                                     |  |
| 17 INFORMANT & ADDRESS <u>Mrs Lawrence M Spencer</u>   |  |                          |  |   |  |                                     |  |
| 18. MEDICAL CERTIFICATION  |  |                          |  |   |  |                                     |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |  |                          |  |   |  |                                     |  |
| IMMEDIATE CAUSE (A) <u>Apoplexy</u>  |  |                          |  | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>  |  |                                     |  |
| ANTECEDENT CAUSE (B) <u>A.C.V.D</u>  |  |                          |  |   |  |                                     |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)   |  |                          |  |   |  |                                     |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>B.P. 14.</u>   |  |                          |  |   |  |                                     |  |
| 19A DATE OF OPERATION <u>1/3/56</u>  |  |                          |  | 19B MAJOR FINDINGS OF OPERATION <u>T.B.P. (M.C. lob)</u>  |  |                                     |  |
| 20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                          |  |   |  |                                     |  |
| 21A ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |  |                          |  | 21B PLACE (Home, farm, factory, street, office bldg., etc.)   |  |                                     |  |
| 21C WHERE DID INJURY OCCUR? (City or town) (County) (State)  |  |                          |  |   |  |                                     |  |
| 21D TIME (Month) (Day) (Year) (Hour) OF INJURY   |  |                          |  | 21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  |                                     |  |
| 21F HOW DID INJURY OCCUR?  |  |                          |  |   |  |                                     |  |
| 22. I hereby certify that I attended the deceased from <u>1954</u> , to <u>1-9, 1956</u> , that I last saw the deceased alive on <u>1-9, 1956</u> , and that death occurred at <u>10<sup>30</sup> AM</u> , from the causes and on the date stated above. |  |                          |  |   |  |                                     |  |
| SIGNATURE <u>[Signature]</u>   |  |                          |  | ADDRESS <u>[Address]</u>  |  |                                     |  |
| DATE SIGNED <u>[Date]</u>  |  |                          |  |   |  |                                     |  |
| 23 BURIAL CREMATION REMOVAL (SPECIFY) <u>Burial</u>  |  |                          |  | DATE THEREOF <u>Jan 12 1956</u>   |  |                                     |  |
| NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>   |  |                          |  | LOCATION (City, town, or county) (State) <u>Easton Md</u>   |  |                                     |  |
| DATE REC'D BY LOCAL REGISTRAR <u>1-14/56</u>   |  |                          |  | REGISTRAR'S SIGNATURE <u>[Signature]</u>  |  |                                     |  |
| 24 FUNERAL DIRECTOR <u>[Signature]</u>   |  |                          |  | ADDRESS <u>[Address]</u>  |  |                                     |  |

RECEIVED  
JAN 17 1956  
BUREAU V. 1

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians' please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01057

## CERTIFICATE OF DEATH

Reg. Dist. No. 270

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH  |  |  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED  |  |  |  |
| COUNTY <u>ALLEGANY</u> MARYLAND<br>CITY (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u><br>TOWN <u>LAUREL</u> LENGTH OF STAY (in this place) <u>26 yrs</u><br>HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>EASTON MEDICAL</u> |  |  |  | STATE <u>MARYLAND</u> COUNTY <u>ALLEGANY</u><br>CITY (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u><br>OR TOWN <u>LAUREL</u> (If rural give location) <u>(1 hr. ASHLAND)</u><br>STREET ADDRESS |  |  |  |
| 3. NAME OF DECEASED (First) (Middle) (Last)  |  |  |  | 4. DATE OF DEATH (Month) (Day) (Year)  |  |  |  |
| NAME OF DECEASED <u>LAURA</u><br>'Type or Print' <u>SPENCER</u>  |  |  |  | DATE OF DEATH <u>1</u> <u>18</u> <u>1956</u>   |  |  |  |
| 5. SEX (M) (F) COLOR OR RACE (Specify)   |  |  |  | 8. DATE OF BIRTH (Month) (Day) (Year)  |  |  |  |
| SEX <u>F</u> COLOR OR RACE <u>WHITE</u> SINGLE MARRIED WIDOWED DIVORCED<br>(Specify) <u>WIDOWED</u>  |  |  |  | DATE OF BIRTH <u>12</u> <u>1884</u> <u>66</u> yrs  |  |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |  |  | 11. BIRTHPLACE (State or foreign country)  |  |  |  |
| <u>HW.</u>   |  |  |  | <u>MD</u>  |  |  |  |
| 10B. KIND OF BUSINESS OR INDUSTRY  |  |  |  | 12. CITIZEN OF WHAT COUNTRY?   |  |  |  |
| <u>HW.</u>   |  |  |  | <u>UNITED STATES</u>   |  |  |  |
| 13. FATHER'S NAME  |  |  |  | 14. MOTHER'S MAIDEN NAME   |  |  |  |
| <u>James Mullikin</u>  |  |  |  | <u>Harriet Mullikin</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unk) If Yes, give war or dates of service  |  |  |  | 17. INFORMANT & ADDRESS  |  |  |  |
|  |  |  |  | <u>Mrs. Bessie Robinson (daughter)</u><br><u>Easton Md</u>   |  |  |  |
| 18. MEDICAL CERTIFICATION  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (A)  |  |  |  | <u>Coronary Thrombosis</u>   |  |  |  |
| ANTECEDENT CAUSE (B)   |  |  |  | <u>Intermittent Coronary Disease</u>   |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.  |  |  |  |  |  |  |  |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH   |  |  |  |  |  |  |  |
| 19A. DATE OF OPERATION   |  |  |  | 19B. MAJOR FINDINGS OF OPERATION   |  |  |  |
| <u>0</u>   |  |  |  |  |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either notify medical examiner)  |  |  |  | 21B. PLACE (Home, farm, factory, street, office bldg., etc.)   |  |  |  |
| <input type="checkbox"/>   |  |  |  | <input type="checkbox"/>   |  |  |  |
| 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)   |  |  |  |  |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  |  |  | 21E. INJURY OCCURRED (While at work) (Not while at work)   |  |  |  |
|  |  |  |  | <input type="checkbox"/> <input type="checkbox"/>  |  |  |  |
| 21F. HOW DID INJURY OCCUR?   |  |  |  |  |  |  |  |
| 22. I hereby certify that I attended the deceased from alive on <u>1/13</u> , 19 <u>56</u> , and that death occurred at <u>10:30</u> A.M., from the causes and on the date stated above.   |  |  |  | DATE SIGNED  |  |  |  |
| SIGNATURE <u>[Signature]</u>   |  |  |  | ADDRESS <u>Easton Md</u>   |  |  |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify)   |  |  |  | NAME OF CEMETERY OR CREMATORY  |  |  |  |
| <u>Buried</u>  |  |  |  | <u>Easton Md</u>   |  |  |  |
| DATE REC'D BY LOCAL REGISTRAR  |  |  |  | 24. FUNERAL DIRECTOR   |  |  |  |
| <u>1/14/56</u>   |  |  |  | <u>[Signature]</u>   |  |  |  |
| REGISTRAR'S SIGNATURE  |  |  |  | ADDRESS  |  |  |  |
| <u>[Signature]</u>   |  |  |  | <u>[Signature]</u>   |  |  |  |

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## CERTIFICATE OF DEATH

Reg. Dist. No. 291

1083

1. PLACE OF DEATH: COUNTY TALBOT MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ROYAL OAK HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MD COUNTY TALBOT CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ROYAL OAK, MD STREET ADDRESS RURAL

3. NAME OF DECEASED: (First) WILLIAM (Middle) T (Last) STANFIELD

4. DATE OF DEATH: (Month) JAN (Day) 3 (Year) 1956

5. SEX: MALE 6. COLOR OR RACE: WHITE 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE 8. DATE OF BIRTH: AUG 2 1871 9. AGE last birthday: 84 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER 10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): ROYAL OAK, MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: CALEB STANFIELD 14. MOTHER'S MAIDEN NAME: MARGARET KERTZ

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) 16. SOCIAL SECURITY No.: 17. INFORMANT'S ADDRESS: John Stanfield, Royal Oak, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) cardiac failure - chronic DUE TO

Antecedent cause(s) (b) arteriosclerotic cardiac vascular DUE TO

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS: hypertension d.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE (Home, farm, factory, street, office bldg., etc.) CITY OR TOWN (COUNTY (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-11-56 to 1-3-56, that I last saw the deceased alive on 1-3-56, and that death occurred at 2:15 A.M. from the causes and on the date stated above.

SIGNATURE Dr. Michael (DEGREE OR TITLE) ADDRESS St. Michaels Md. 1-3-56 DATE SIGNED

23. BURIAL, CREMATION, REINTERMENT (Specify): Burial DATE THEREOF Jan 5, 1956 NAME OF CEMETERY OR CREMATORY Springhill Cemetery LOCATION (City, town, or county) (State) Easton, Maryland

DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE Jan 14, 1956 Miss Robert R. Self FURNERAL DIRECTOR'S SIGNATURE St. Michaels ADDRESS Md

BUREAU V. 3.

JAN 5 1930

RECEIVED

## CERTIFICATE OF DEATH

01059

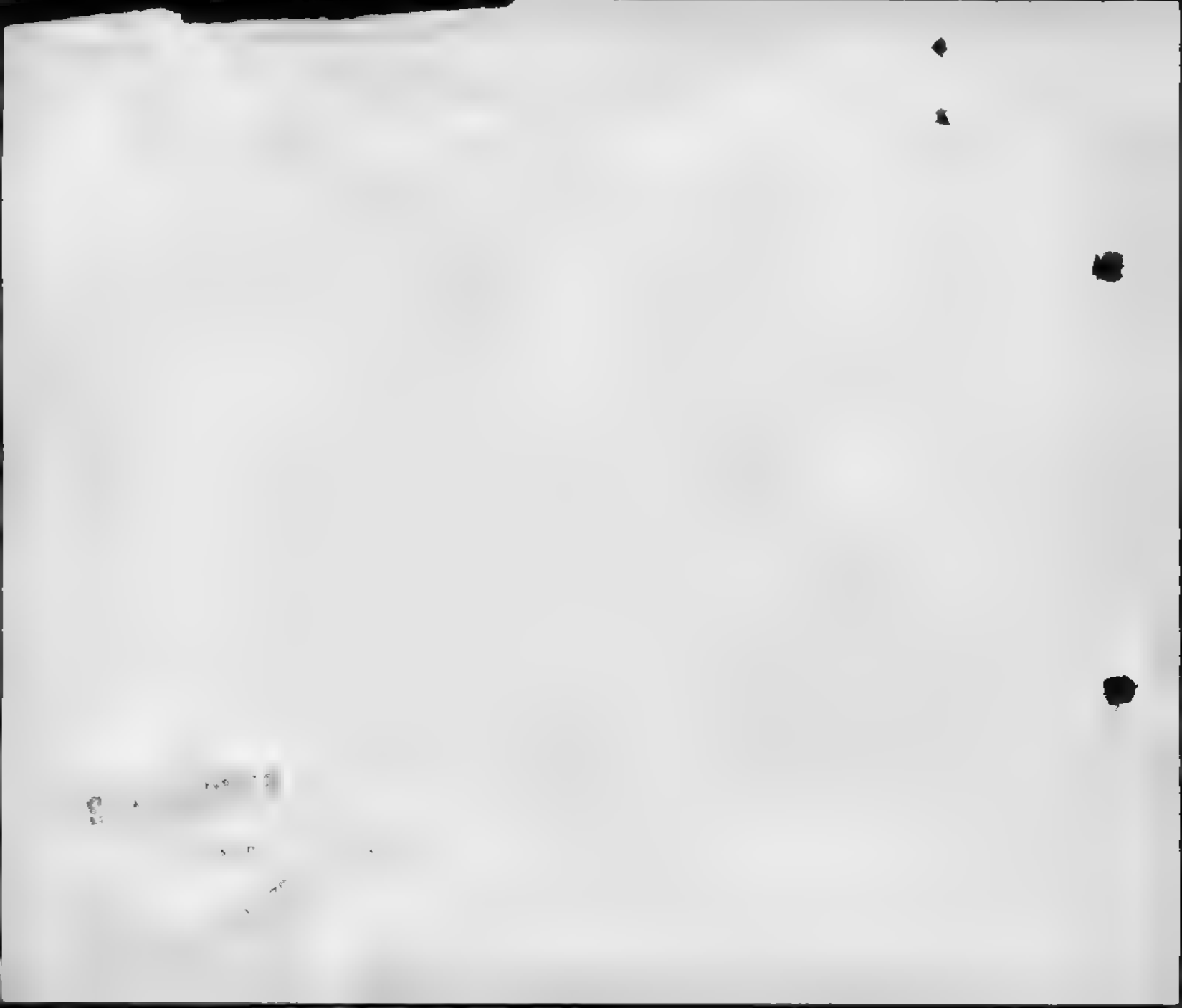
Reg. Dist. No. 290

|   |                           |  |                                |  |                                 |  |                |
|---|---------------------------|--|--------------------------------|--|---------------------------------|--|----------------|
| 1. PLACE OF DEATH   |                           |  |                                | 2. USUAL RESIDENCE (HOME) OF DECEASED  |                                 |  |                |
| COUNTY <u>Talbot</u>  |                           | STATE <u>Maryland</u>  |                                | COUNTY <u>Talbot</u>   |                                 | STATE <u>Maryland</u>                    |                |
| CITY (If outside corporate limits, write RURAL and give nearest town)   |                           | LENGTH OF STAY (In this place)   |                                | CITY (If outside corporate limits, write RURAL and give nearest town)            |                                 | LENGTH OF STAY (In this place)           |                |
| TOWN <u>Castro</u>  |                           | <u>2 days</u>  |                                | TOWN <u>Cordova</u>  |                                 | <u>2 days</u>                            |                |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>  |                           |  |                                | STREET ADDRESS (If rural give location)  |                                 |  |                |
| 3. NAME OF DECEASED (Type or Print)   |                           |  |                                | 4. DATE OF DEATH   |                                 |  |                |
| <u>Baby Boy</u>   |                           |  |                                | <u>1 5 1956</u>  |                                 |  |                |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)   | 8. DATE OF BIRTH <u>1-3-56</u> | 9. AGE last birthday yrs. <u>2</u>   | IF UNDER 1 YEAR Months <u>2</u> | IF UNDER 24 HRS Days <u>2</u>            | Hours <u>2</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                           | 10b. KIND OF BUSINESS OR INDUSTRY  |                                | 11. BIRTHPLACE (State or foreign country)  |                                 | 12. CITIZEN OF WHAT COUNTRY?             |                |
|   |                           |  |                                | <u>Maryland</u>  |                                 | <u>U.S.A.</u>                            |                |
| 13. FATHER'S NAME <u>William D. Steward</u>   |                           |  |                                | 14. MOTHER'S MAIDEN NAME <u>Nancy Hutchison</u>                                  |                                 |  |                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)   |                           |  |                                | 16. SOCIAL SECURITY NO.  |                                 | 17. INFORMANT & ADDRESS                  |                |
|   |                           |  |                                |  |                                 | <u>Mr William D Steward</u>              |                |
| 18. MEDICAL CERTIFICATION   |                           |  |                                | INTERVAL BETWEEN ONSET AND DEATH   |                                 |  |                |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                           |  |                                |  |                                 |  |                |
| IMMEDIATE CAUSE (A) <u>Intra-aortic hemorrhage</u>  |                           |  |                                |  |                                 |  |                |
| ANTECEDENT CAUSE(S) DUE TO <u>Fracture of the tibia</u>   |                           |  |                                |  |                                 |  |                |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)  |                           |  |                                |  |                                 |  |                |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>Congenital hydrocephalus</u>  |                           |  |                                |  |                                 |  |                |
| 19a. DATE OF OPERATION <u>2</u>   |                           | 19b. MAJOR FINDINGS OF OPERATION   |                                | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                 |  |                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |                           | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                                 |                                | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)                     |                                 |  |                |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)   |                           | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |                                | 21f. HOW DID INJURY OCCUR?   |                                 |  |                |
|   |                           |  |                                |  |                                 |  |                |
| 22. I hereby certify that I attended the deceased from . . . . . 19 . . . . . to . . . . . 19 . . . . . that I last saw the deceased alive on . . . . . and that death occurred at 8:45 P.M. from the causes and on the date stated above |                           |  |                                |  |                                 |  |                |
| SIGNATURE <u>W. H. Schmitt</u> M.D. <u>Castro</u> DATE SIGNED <u>6 Jan 1956</u>   |                           |  |                                |  |                                 |  |                |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)  |                           | DATE THEREOF   |                                | NAME OF CEMETERY OR CREMATORY  |                                 | LOCATION (City, town, or county) (State) |                |
|   |                           | <u>1-6-56</u>  |                                | <u>Fairview</u>  |                                 | <u>Cordova, Md.</u>                      |                |
| 24. REC'D BY REGISTRAR  |                           | REGISTRAR'S SIGNATURE  |                                | 25. FUNERAL DIRECTOR'S SIGNATURE   |                                 | ADDRESS                                  |                |
| DATE <u>1-6-56</u>  |                           | <u>H. H. Heskett</u>   |                                | <u>Howard H. Heskett</u>   |                                 |  |                |

1 TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be filed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filed in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ASC 1-53 10M



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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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## CERTIFICATE OF DEATH

Reg. Dist. No. 290

## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 155 104

|  |  |   |   |   |  |  |  |
|--|--|---|---|---|--|--|--|
| <b>1. PLACE OF DEATH</b>   |  |   |   | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>  |  |  |  |
| COUNTY <u>Talbot</u>   |  | STATE <u>Maryland</u>   |   | COUNTY <u>Talbot</u>  |  |  |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>Easton</u>   |  | LENGTH OF STAY (in this place)<br><u>Life</u>   |   | CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>Royal Oak</u> |  |  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>Highway</u>  |  |   |   | STREET ADDRESS<br><u>Box 196</u>  |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or Print) <u>Alfred Coxen Thomas</u>   |  |   |   | <b>4. DATE OF DEATH</b><br>(Month) <u>1</u> (Day) <u>13</u> (Year) <u>1956</u>            |  |  |  |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>Col</u>               | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><u>Single</u>  | 8. DATE OF BIRTH<br><u>3/9/30</u>                                       | 9. AGE last birthday<br><u>24</u> yrs.  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Laborer</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Lumberman</u>   |   | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>                              |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>  </u>          |  |
| 13. FATHER'S NAME<br><u>Robert Woodland Thomas</u>   |  |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Mildred Coxen</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unk.) <u>yes</u> (If Yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO.<br><u>  </u>  |   | 17. INFORMANT & ADDRESS<br><u>Mrs. Mildred Coxen</u>                                      |  |  |  |
| <b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>   |  |   |   | <b>18. MEDICAL CERTIFICATION</b>  |  |  |  |
| IMMEDIATE CAUSE (A) <u>Multiple fractures</u>  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>Minutes</u>  |  |  |  |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Auto accident</u>  |  |   |   |   |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>  </u>  |  |   |   |   |  |  |  |
| STATING UNDERLYING CAUSE LAST.   |  |   |   |   |  |  |  |
| <b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>   |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION<br><u>  </u>  |  | 19b. MAJOR FINDINGS OF OPERATION<br><u>  </u>   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>   |  | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)<br><u>Home</u>                             |   | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)<br><u>Easton Talbot Md</u>   |  |  |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)<br><u>20 1 13 56 1956</u>  |  | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> |   | 21f. HOW DID INJURY OCCUR?<br><u>Drove car into road grader</u>                           |  |  |  |
| 22. I hereby certify that I attended the deceased from <u>  </u> , 19 <u>  </u> , to <u>  </u> , 19 <u>  </u> , that I last saw the deceased alive on <u>  </u> , 19 <u>  </u> , and that death occurred at <u>  </u> M. from the causes and on the date stated above. |  |   |   |   |  |  |  |
| SIGNATURE<br><u>Lewis W. DME</u>   |  |   |   | ADDRESS (Street, city, town, state)<br><u>Easton Md</u>                                   |  | DATE SIGNED<br><u>1-14-56</u>                      |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>  | DATE THEREOF<br><u>1/16/56</u>               | NAME OF CEMETERY OR CREMATORY<br><u>Royal Oak Cem.</u>  |   | LOCATION (City, town, or county)<br><u>Royal Oak Md.</u>                                  |  | (State)<br><u>  </u>                               |  |
| 24. REC'D BY REGISTRAR<br><u>  </u>  | REGISTRAR'S SIGNATURE<br><u>N. H. Newlin</u> |   | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>James B. Cahill, Easton, Md.</u> |   |  |  |  |
| DATE<br><u>1/14/56</u>   |  |   |   |   |  |  |  |

# CERTIFICATE OF DEATH

THE

DEPARTMENT OF JUSTICE - BUREAU OF PRISONS

1. Name of deceased: \_\_\_\_\_  
2. Age: \_\_\_\_\_  
3. Sex: \_\_\_\_\_  
4. Race: \_\_\_\_\_  
5. Date of birth: \_\_\_\_\_  
6. Date of death: \_\_\_\_\_  
7. Place of death: \_\_\_\_\_  
8. Cause of death: \_\_\_\_\_  
9. Manner of death: \_\_\_\_\_  
10. Signature of physician: \_\_\_\_\_  
11. Signature of coroner: \_\_\_\_\_  
12. Signature of witness: \_\_\_\_\_  
13. Signature of official: \_\_\_\_\_

BUREAU V. 2

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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1084

## CERTIFICATE OF DEATH

Reg. Dist. No. 291

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH:  |  |  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:                                |  |  |  |
| COUNTY <u>TALBOT</u>  |  | MARYLAND   |  | STATE <u>Md</u>   |  | COUNTY <u>Talbot</u>                       |  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)  |  | LENGTH OF STAY (in this place)   |  | CITY (If outside corporate limits, write RURAL and give nearest town) |  |  |  |
| X TOWN <u>WITTMAN</u>   |  | <u>LIFE</u>  |  | OR TOWN <u>Wittman</u>  |  |  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS   |  |  |  | STREET ADDRESS (If rural give location)                               |  |  |  |
| 3. NAME OF DECEASED: (Type or Print)  |  |  |  | 4. DATE (Month) (Day) (Year)  |  |  |  |
| (First) <u>WELBY</u>  |  | (Middle) <u>-</u>  |  | (Last) <u>WILLEY</u>  |  | DATE OF DEATH: <u>Jan 14</u> 1956          |  |
| 5. SEX: <u>MALE</u>   |  | 6. COLOR OR RACE: <u>WHITE</u>   |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>      |  | 8. DATE OF BIRTH: <u>AUG 26-1899</u>       |  |
| 9. AGE last birthday <u>58</u> yrs.   |  | 10. AGE last birthday (If UNDER 1 YEAR) Months Days Hours Min.   |  | 11. BIRTHPLACE (State or foreign country): <u>ST. MICHAELS Md</u>     |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>WATERMAN</u>  |  |  |  | 10B. KIND OF BUSINESS OR INDUSTRY: <u>SEAFOOD</u>                     |  |  |  |
| 13. FATHER'S NAME: <u>CHARLES WILLEY</u>  |  |  |  | 14. MOTHER'S MAIDEN NAME: <u>JULIAN GODWIN</u>                        |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NONE</u>   |  |  |  | 16. SOCIAL SECURITY NO. <u>NONE</u>                                   |  |  |  |
| 17. INFORMANT & ADDRESS: <u>Mrs Welby Willey, Wittman Md.</u>   |  |  |  |   |  |  |  |
| 18. MEDICAL CERTIFICATION   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH                                      |  |  |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:   |  |  |  |   |  |  |  |
| 199.1 IMMEDIATE CAUSE   |  |  |  | 3 yrs   |  |  |  |
| ANTECEDENT CAUSE (S)  |  |  |  | 4 yrs   |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.   |  |  |  |   |  |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |  |  |  |   |  |  |  |
| 19A. DATE OF OPERATION: <u>0</u>  |  |  |  | 19B. MAJOR FINDINGS OF OPERATION                                      |  |  |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |   |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |  | 21C. WHERE DID (City or town) (County) (State)                        |  | 21D. HOW DID INJURY OCCUR?                 |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  |   |  |  |  |
| 22. I hereby certify that I attended the deceased from 1950 to Jan 14, 1956 that I last saw the deceased alive on Jan 14, 1956 and that death occurred at 6 P. M. from the causes and on the date stated above. |  |  |  |   |  |  |  |
| SIGNATURE <u>Robert L. Scott</u>  |  | M.D. <u>T. Talbot</u>  |  | DATE SIGNED <u>Jan 17, 1956</u>                                       |  |  |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | DATE THEREOF   |  | NAME OF CEMETERY OR CREMATORY   |  | LOCATION (City, town, or county) (State)   |  |
| <u>Burial</u>   |  | <u>11/17/56</u>  |  | <u>White Cemetery</u>   |  | <u>St. Michaels Md.</u>                    |  |
| DATE REC'D BY LOCAL REGISTRAR   |  | REGISTRAR'S SIGNATURE  |  | 24. FUNERAL DIRECTOR  |  | ADDRESS                                    |  |
| <u>Jan 17, 1956</u>   |  | <u>Mrs Robert L. Scott</u>   |  | <u>L. Hamilton</u>  |  | <u>St. Michaels Md.</u>                    |  |

RECEIVED

JAN 18 1956

BUREAU V. S.